SCOTTSMILES

City of Scottsdale Dental PPO Plan Claim Form

PROCEDURE FOR FILING A CLAIM

1. Complete all questions on this form.
2. Only submit itemized bills. We cannot accept photocopies, balance due statements, or cash register receipts.
   Documentation must included the following:
   Description of services (ADA procedure code) or supplies provided, detailing the charge for each supply or service; Diagnosis; Date(s) of service; Patient's name; Provider's name, address, phone number and degree; Federal tax identification number of the provider.
   If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the benefits claim form sent to this plan.
3. Mail to address below.

MUST BE COMPLETED BY EMPLOYEE

1. EMPLOYEE NAME (PRINT) LAST FIRST MIDDLE
2. BIRTH DATE MO. DA. YR.
SEX ☐ M ☐ F
3. EMPLOYEE # OR SOCIAL SECURITY #

4. ADDRESS CITY STATE ZIP
5. TELEPHONE NO.

6. PATIENT NAME
7. RELATIONSHIP TO EMPLOYEE
8. PATIENT BIRTH DATE MO DA YR
9. IS PATIENT F/T STUDENT ☐ YES ☐ NO
NAME OF SCHOOL
CREDIT HOURS

10. SPOUSE'S NAME
11. SPOUSE'S BIRTH DATE MO DA YR
11A. SPOUSE'S SOCIAL. SEC.URITY NUMBER

12. SPOUSE'S EMPLOYER NAME AND ADDRESS
13. CITY STATE ZIP
14. DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO
IF YES, CO. NAME
ADDRESS
POLICY NO.

15. DOES SPOUSE HAVE OTHER COVERAGE? ☐ YES ☐ NO
16. DID INJURY OCCUR WHILE ON THE JOB? ☐ YES ☐ NO
17. IS CLAIM A RESULT OF ☐ ILLNESS ☐ ACCIDENT
18. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED MO. DA. YR.
19. IS THERE OTHER COVERAGE FOR THIS ACCIDENT? ☐ YES ☐ NO

20. HOW AND WHERE DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?
21. HAVE YOU FILED FOR WORKER'S COMPENSATION FOR THIS CONDITION? ☐ YES ☐ NO

22. AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE THE PROVIDER OF SERVICES RELATED TO THIS CLAIM TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I ALSO CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE.

PATIENT OR PARENT - GUARDIAN IF MINOR DATE

23. AUTHORIZATION TO PAY BENEFITS PROVIDER

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS/HER SERVICES AS DESCRIBED HEREIN NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I ALSO CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE.

PATIENT OR PARENT - GUARDIAN IF MINOR DATE

AEI, Inc.
5810 W. Beverly Lane
Glendale, AZ 85306-1800

(602) 789-1170